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NOTICE OF INDEPENDENT REVIEW DECISION

DATE NOTICE SENT TO ALL PARTIES: Aug/28/2015

IRO CASE #:

DESCRIPTION OF THE SERVICE OR SERVICES IN DISPUTE: LESI L5-S1 left with epidurogram for lower back

A DESCRIPTION OF THE QUALIFICATIONS FOR EACH PHYSICIAN OR OTHER HEALTH CARE PROVIDER WHO REVIEWED THE DECISION: MD, Board Certified Anesthesiology

REVIEW OUTCOME: Upon independent review, the reviewer finds that the previous adverse determination/adverse determinations should be:

[X] Upheld (Agree)
[ ] Overturned (Disagree)
[ ] Partially Overturned (Agree in part/Disagree in part)

Provide a description of the review outcome that clearly states whether medical necessity exists for each health care service in dispute. It is the opinion of the reviewer that the request for LESI L5 S1 left with epidurogram for lower back is not recommended as medically necessary

PATIENT CLINICAL HISTORY [SUMMARY]: The patient is a female whose date of injury is xx/xx/xx. The submitted records document a prior history of lower back problems in xxxx. Medical record review dated xxxx indicates that the patient underwent percutaneous discectomy at L4-5 on xxxx. The patient underwent lumbar epidural steroid injection in xxxx xxxx and reported 50% pain relief for 4 weeks. Office visit note dated xxxx indicates that the patient complains of lumbar spine pain rated as 6/10. Current medications are hydrocodone-acetaminophen, Lyrica and oxybutynin chloride. On physical examination deep tendon reflexes are 1+ bilateral knees. There is no evidence of stocking or glove sensory loss in the lower extremities. MRI of the lumbar spine dated xxxxx revealed at L5-S1 degenerative changes are present about the facet joints.

Initial request for lumbar epidural steroid injection left L5-S1 with epidurogram for lower back was non-certified on xxxxx noting that the Official Disability Guidelines require documentation of radiculopathy on physical examination corroborated by imaging studies and/or electrodiagnostic results. The submitted lumbar MRI fails to document any significant neurocompressive pathology. Additionally, the patient underwent prior epidural steroid injection and reported 50% pain relief for 4 weeks. The Official Disability Guidelines require documentation of at least 50% pain relief for at least 6 weeks prior to repeat epidural steroid injection. The denial was upheld on appeal dated xxx noting that a lumbar epidural steroid injection in xxxx xxxx provided 50% pain relief for xxx weeks. The records provided fail to identify neural compression at L5-S1 on the MRI, and there is documented previous injection without the recommended pain relief.

ANALYSIS AND EXPLANATION OF THE DECISION INCLUDE CLINICAL BASIS, FINDINGS AND CONCLUSIONS USED TO SUPPORT THE DECISION: The patient sustained injuries on xxxx. There is no documentation of any recent active treatment. The submitted clinical records

report that the injured worker underwent a lumbar epidural steroid injection in xxxx xxxxx with 50% pain relief reported for xxxx weeks. The Official Disability Guidelines Low Back Chapter states that if after the initial block/blocks are given (and found to produce pain relief of at least 50-70% pain relief for at least xxxxx weeks, additional blocks may be supported. Repeat injections should be based on continued objective documented pain relief, decreased need for pain medications, and functional response. Additionally, the Official Disability Guidelines require documentation of radiculopathy on physical examination corroborated by imaging studies and/or electrodiagnostic results. The patient's lumbar MRI documents at L5-S1 there are degenerative changes about the facet joints at the requested level. As such, it is the opinion of the reviewer that the request for LESI L5 S1 left with epidurogram for lower back is not recommended as medically necessary and the prior denials are upheld.

A DESCRIPTION AND THE SOURCE OF THE SCREENING CRITERIA OR OTHER CLINICAL BASIS USED TO MAKE THE DECISION:

[ ] ACOEM-AMERICA COLLEGE OF OCCUPATIONAL & ENVIRONMENTAL MEDICINE UM KNOWLEDGEBASE

[ ] AHCPR-AGENCY FOR HEALTHCARE RESEARCH & QUALITY GUIDELINES

[ ] DWC-DIVISION OF WORKERS COMPENSATION POLICIES OR GUIDELINES

[ ] EUROPEAN GUIDELINES FOR MANAGEMENT OF CHRONIC LOW BACK PAIN

[ ] INTERQUAL CRITERIA

[X] MEDICAL JUDGEMENT, CLINICAL EXPERIENCE, AND EXPERTISE IN ACCORDANCE WITH ACCEPTED MEDICAL STANDARDS

[ ] MERCY CENTER CONSENSUS CONFERENCE GUIDELINES

[ ] MILLIMAN CARE GUIDELINES

[X] ODG-OFFICIAL DISABILITY GUIDELINES & TREATMENT GUIDELINES

[ ] PRESSLEY REED, THE MEDICAL DISABILITY ADVISOR

[ ] TEXAS GUIDELINES FOR CHIROPRACTIC QUALITY ASSURANCE & PRACTICE PARAMETERS

[ ] TEXAS TACADA GUIDELINES

[ ] TMF SCREENING CRITERIA MANUAL

[ ] PEER REVIEWED NATIONALLY ACCEPTED MEDICAL LITERATURE (PROVIDE A DESCRIPTION)

[ ] OTHER EVIDENCE BASED, SCIENTIFICALLY VALID, OUTCOME FOCUSED GUIDELINES (PROVIDE A DESCRIPTION)